1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08924

8928 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R 2 Sykesville
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md — b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) × Rural Sykesville
d. STREET ADDRESS R 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LONNIE Middle ROBERT Last BOLLINGER

4. DATE OF DEATH: Month Aug Day 28 Year 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 1 1958
9. AGE (In years if last birthday) yrs.
IF UNDER 1 YEAR: Months 4 Days 27
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Montgomery Co. Hosp. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Robert Bollinger
14. MOTHER'S MAIDEN NAME: Sandra Lee Coleman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Address: Mr John R. Bollinger - Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Undetermined — INTERVAL BETWEEN ONSET AND DEATH: Hours
795.5
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour ___ a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh M.D.
EXAMINER'S NAME (Type): JAMES T. MARSH
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5/28/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-30-58
22c. NAME OF CEMETERY OR CREMATORY: Freedom
22d. LOCATION (City, town, or county) (State): Eldersburg Carroll Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haight ADDRESS: Sykesville, Md.
24a. REC'D BY REGISTRAR DATE: SEP 4 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08925

8929 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and with the State Board of Health; or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Taneytown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Ohio — b. COUNTY: Cuyahoga
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): University Heights
d. STREET ADDRESS: 2307 Lalemont Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle MICHAEL Last BONACKER
4. DATE OF DEATH: Month Aug Day 21 Year 1958
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-11-36
9. AGE (In years last birthday): 22 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Air Force
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't
11. BIRTHPLACE (State or foreign country): Cleveland, Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry C. Bonacker
14. MOTHER'S MAIDEN NAME: Mary Jenkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): Present time
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Millard Son & Raper Co., Cleveland, Ohio

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): FRAC. SKULL - CRUSHING INJURY — Interval between onset and death: Min.
825X
DUE TO (b): L. CHEST — MULTIPLE FRAC. L. FEMUR
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Automobile Accident
20c. TIME OF INJURY: Hour 6 o. m. — Month, Day, Year: 8/21/58
20d. INJURY OCCURRED: White at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): R 194
20f. (City or town) Taneytown (County) Carroll (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James J. Mard M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): JAMES J. MARSH
DATE SIGNED: 8/21/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: % Millard Son & Raper Company
22c. NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City, town, or county) (State): Cleveland, Ohio

23. FUNERAL DIRECTOR'S SIGNATURE: Merwyn C. Fuss
ADDRESS: C.O. Fuss & Son, Taneytown, Maryland
24a. RECD BY REGISTRAR DATE: AUG 25 58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08926

8930

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Taneytown
c. LENGTH OF STAY IN 1b: 60 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Taneytown
d. STREET ADDRESS: E. Baltimore Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles; Middle: F.; Last: Cashman

4. DATE OF DEATH: Month: August; Day: 6; Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 13, 1884

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Estate Broker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Abdiel Cashman

14. MOTHER'S MAIDEN NAME: Laura E. Sell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Mrs. Jessie Cashman, Taneytown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:
420.1
DUE TO
(b): Chronic Myocarditis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 6, 1958 to Aug 6, 1958, that I last saw the deceased alive on Aug 5, 1958, and that death occurred at 7.30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. N. Legg M.D.
ADDRESS (Street, city or town, state): Union Bridge Md
DATE SIGNED: 8-6-58

PHYSICIAN'S NAME (Type): Thomas H. Legg, M.D. Union Bridge, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 9, 1958
22c. NAME OF CEMETERY OR CREMATORY: Lutheran Cemetery
22d. LOCATION (City, town, or county) (State): Taneytown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Clarence C. Fuss
ADDRESS: C.O.Fuss & Son Taneytown, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 7 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8931

CERTIFICATE OF DEATH

68927
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2 mos. 16 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

d. STREET ADDRESS: 4541 Windsor Lane

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Catherine Middle: Rennecker Benson Last: Castillo

4. DATE OF DEATH: Month: August Day: 12, Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 1, 1899

9. AGE (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Kentucky

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Benson

14. MOTHER'S MAIDEN NAME: Effie Kennedy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield Hospital Records
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of cervix
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3 years plus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Manic depressive reaction, manic type.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 26, 1958, to August 12, 1958, that I last saw the deceased alive on August 11, 1958, and that death occurred at 1:30A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 8/12/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 15, 1958
22c. NAME OF CEMETERY OR CREMATORY: Valleyview Mem Park
22d. LOCATION (City, town, or county) (State): Cabin John Md.

23. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS: Lee Funeral Home - Washington, D.C.

24a. REC'D BY REGISTRAR DATE: AUG 14 58

24b. REGISTRAR'S SIGNATURE: Arthur L. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

08928

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8932 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 3 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL WESTMINSTER MIN.
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ROUTE 140

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYATTSVILLE
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LEROY — Middle: ELWOOD — Last: DE HART

4. DATE OF DEATH: Month: Aug — Day: 30 — Year: 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 1913

9. AGE (In years last birthday): 45 yrs.

IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): PA.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: CYRUS DE HART

14. MOTHER'S MAIDEN NAME: MABEL BEAVER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): WW II (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: CYRUS DE HART, DEWART, PA.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): FRAC SKULL - CRUSHING INJURY TO CHEST — INTERVAL BETWEEN ONSET AND DEATH: MIN
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

823 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): One car automobile accident - car hit tree

20c. TIME OF INJURY Hour: 1:45 a.m. — Month, Day, Year: 8-30 1958

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 140

20f. (City or town) (County) (State): WESTMINSTER CARROLL MD

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh M.D.
EXAMINER'S NAME (Type): JAMES T MARSH
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8-30-58

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: SEPT 1, 58
22c. NAME OF CEMETERY OR CREMATORY: MILTON CEM.
22d. LOCATION (City, town, or county) (State): MILTON, PA.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: David C. Bankard Westminster Md

24a. RECD BY REGISTRAR DATE: SEP 4 58

24b. REGISTRAR'S SIGNATURE: Conrad L. Myers

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8933

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08929

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TANEYTOWN
c. LENGTH OF STAY IN 1b YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RURAL

2. USUAL RESIDENCE (Where deceased lived. If inst tut on Residence before adm ssion)
a. STATE MARYLAND b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TANEYTOWN
d. STREET ADDRESS 1 RURAL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First RAYMOND Middle AUGUSTUS Last ECKARD
4. DATE OF DEATH Month AUGUST Day 7 Year 1958
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH JUNE 5 1905
9. AGE (In years last birthday) 53 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER
10b. KIND OF BUSINESS OR INDUSTRY BUILDING
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME LUTHER ECKARD
14. MOTHER'S MAIDEN NAME BESSIE REINAMAN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) No
16. SOCIAL SECURITY NO 214-16-1504
17. INFORMANT MRS ILEAN P. ECKARD
Address TANEYTOWN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH 7 Hours
DUE TO (b) CORONARY SCLEROSIS — WEEKS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE James T. Marsh M.D.
EXAMINER'S NAME (Type) JAMES T. MARSH
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 8/7/58

22a. BURIAL CREMATION REMOVAL (Specify) BURIAL
22b. DATE THEREOF 8/9/58
22c. NAME OF CEMETERY OR CREMATORY REFORMED CEM
22d. LOCATION (City, town, or county) TANEYTOWN (State) MD
23. FUNERAL DIRECTOR'S SIGNATURE D.D. Hartzler & Sons
ADDRESS New Windsor Md
24a. REC'D BY REGISTRAR DATE AUG 11 '58
24b. REGISTRAR'S SIGNATURE W. Leach

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8934

CERTIFICATE OF DEATH

08930

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL WESTMINSTER
c. LENGTH OF STAY IN 1b: 4 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: BOND ST. EXT

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: MD.
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle W Last FOGLE JR
4. DATE OF DEATH: Month AUG Day 11 Year 1958

5. SEX: MALE
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: NOV. 30, 1873
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gardner
10b. KIND OF BUSINESS OR INDUSTRY: Landscape
11. BIRTHPLACE (State or foreign country): MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN W. FOGLE SR.
14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 214-14-5935
17. INFORMANT: JOSEPH D. FOGLE
Address: BOND ST. EXT. WESTMINSTER MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO (b): Hypertension — 1 year.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

444X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Prostatectomy

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 10, 19 58, to Aug. 11, 19 58, that I last saw the deceased alive on Aug 11 19 58, and that death occurred at 8:02 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Julius Chopko M.D.
ADDRESS (Street, city or town, state): Box 6 Westminster Md
DATE SIGNED: 8/12/58
PHYSICIAN'S NAME (Type): Julius Chopko

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: AUG 13 58
22c. NAME OF CEMETERY OR CREMATORY: HAUGH'S CEM.
22d. LOCATION (City, town, or county): FETMAR (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE: David C. Bankard
ADDRESS: Westminster, Md.
24a. REC'D BY REGISTRAR DATE: AUG 15 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Koons

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper sheets. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08931

: 8935

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 32yrs.10mos.16days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2037 Eagle Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ida; Middle; Last FRIEDLANDER

4. DATE OF DEATH: Month August; Day 3; Year 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Unknown

9. AGE (In years last birthday): 70 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? Russia

13. FATHER'S NAME: Abraham -

14. MOTHER'S MAIDEN NAME: Betty -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO: -

17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic reaction, paranoid type.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from October 20, 1954, to August 3, 1958, that I last saw the deceased alive on August 3, 1958, and that death occurred at 11:05A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 8/4/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 5/58
22c. NAME OF CEMETERY OR CREMATORY: Odd Fellows
22d. LOCATION (City, town, or county) (State): Balto Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Jos. Seaman & Bro. Inc
ADDRESS: 1124-26 N. Paca Ave

24a. REC'D BY REGISTRAR DATE: AUG 6 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8936

08932

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND	2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Garrett
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville	c. LENGTH OF STAY IN 1b: 9yrs.10mos.2da.
	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Friendsville, Maryland
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital	d. STREET ADDRESS
	e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Mollie		Friend	August	15	1958

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
Female	White		8/11/75	83 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	- Home	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Isaiah Friend	Julia Casteele

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	-	Springfield State Hospital, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	arteriosclerotic heart disease	years
420.0 DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO		
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senile Psychosis, agitated type. Macrocytic anemia.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour / Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
a. m. / p. m. 19			

21. I certify that I attended the deceased from October 29, 1954, to August 15, 1958, that I last saw the deceased alive on August 14, 1958, and that death occurred at 6:24 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D. ADDRESS (Street, city or town, state): Sykesville, Maryland DATE SIGNED: 8/15/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D. Springfield State Hospital

22a BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county) (State)
Burial	8/17/1958	Hoyes Cemetery	Garrett County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b REGISTRAR'S SIGNATURE
H. C. Leighton	Oakland, Md.	AUG 19 '58	Arthur S. Evans

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MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

8937

CERTIFICATE OF DEATH

08933

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon sheets. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hampstead Rural
c. LENGTH OF STAY IN 1b: 25 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ✓

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hampstead (Rural)
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First PANSY Middle L Last GARLAND

4. DATE OF DEATH: Month Aug Day 29 Year 19 58

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 24 1883

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Letterman

14. MOTHER'S MAIDEN NAME: Louise Riddle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: No

17. INFORMANT: Address: Mr Doris Garland - Hampstead Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Myocarditis

DUE TO (b): Arteriosclerotic Cardio-Renal Vascular disease

DUE TO (c): Generalized Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442 X

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from June 25, 1958, to August 28, 1958, that I last saw the deceased alive on August 28, 1958, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph E Bush M.D. ADDRESS (Street, city or town, state): Hampstead Md DATE SIGNED: 8/29/58

PHYSICIAN'S NAME (Type): Joseph E. Bush MD HAMPSTEAD Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: aug 31/58

22c. NAME OF CEMETERY OR CREMATORY: Hampstead

22d. LOCATION (City, town, or county) (State): Carroll Co Md

23. FUNERAL DIRECTOR'S SIGNATURE: Edw A Tipton ADDRESS: Hampstead Md

24a. REC'D BY REGISTRAR DATE: SEP 2 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

: 8938 **CERTIFICATE OF DEATH**

08934

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Balto.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Reisterstown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Grand View Nursing Home

d. STREET ADDRESS: 620 Main Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ruth Middle: E. Last: Garman

4. DATE OF DEATH: Month: Aug. Day: 11 Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov.24,1874

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Glaenzer

14. MOTHER'S MAIDEN NAME: Regina Wagner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Mrs.Elsie P.Hale Reisterstown,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertensive cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): senility

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 22, 1955, to Aug. 11, 1958, that I last saw the deceased alive on Aug 11, 1958, and that death occurred at 5:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. H. Lawson Jr. M.D. ADDRESS (Street, city or town, state): Liberty Road at Eldersburg DATE SIGNED: 8.11.58

PHYSICIAN'S NAME (Type): Wm. H. Lawson, Jr., M.D. Sykesville P.O., Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug.13,58

22c. NAME OF CEMETERY OR CREMATORY: Louden Park Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J.F.Eline & Sons Reisterstown,Md.

24a. REC'D BY REGISTRAR DATE: AUG 12 1958

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 3233 8/28/58 gpf

CERTIFICATE OF DEATH

8939

Reg. Dist. No. 08935

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2 m 10 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 811 Madison Ave. Windsor Park Home, Windsor Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillie — Middle: Mae — Last: Garrett
4. DATE OF DEATH: Month: 8 — Day: 15 — Year: 1958
5 SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5 - ? - 76
9 AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: James Garrett
14. MOTHER'S MAIDEN NAME: Sarah Jane
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: unkn
17. INFORMANT — Address: Springfield State Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: years
420.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CBS, assoc. with senile brain disease, with psych. reaction
Cellulitis, right buttock
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-5- , 1958, to 8-15- , 1958, that I last saw the deceased alive on 8-15- , 1958, and that death occurred at 10:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 8-16-58
PHYSICIAN'S NAME (Type): Edmund Lusthaus M.D. — Sykesville, Maryland.

22a BURIAL, CREMATION, REMOVAL (Specify) — 22b. DATE THEREOF — 22c. NAME OF CEMETERY OR CREMATORY: W. & M. Anatomy Board — 22d. LOCATION (City, town, or county) (State)

23 FUNERAL DIRECTOR'S SIGNATURE: Frank D. Newell — ADDRESS: Sykesville, Md.
24a. REC'D BY REGISTRAR — DATE: AUG 21 '58
24b REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

Page 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8940

CERTIFICATE OF DEATH

Reg. Dist. No. 08936

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 4yrs.9mos.4days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 14
d. STREET ADDRESS: 5016 Pilgrim Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary Middle Elizabeth Last Parker GROSS

4. DATE OF DEATH: Month August Day 4, Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: October 22, 1872
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frederick Parker
14. MOTHER'S MAIDEN NAME: Justina Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO: -
17. INFORMANT: Springfield Hospital Records. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Passive congestion of heart — INTERVAL BETWEEN ONSET AND DEATH: Days

DUE TO (b): Arteriosclerotic heart disease — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.assoc.with dist.of growth,metabolism or nutrition,with senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 20, 1954 to August 4, 1958 that I last saw the deceased alive on August 4, 1958, and that death occurred at 4:00P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D. ADDRESS (Street, city or town, state): Springfield State Hospital DATE SIGNED: 8/4/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D. Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 8-7-58
22c. NAME OF CEMETERY OR CREMATORY: Parkwood
22d. LOCATION (City, town, or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE: Leonard J Luck ADDRESS: 1305 Harford
24a. REC'D BY REGISTRAR DATE: AUG 7 '58
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8941

CERTIFICATE OF DEATH

Reg. Dist. No. 08937

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER
c. LENGTH OF STAY IN 1b 78 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 102 LIBERTY ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural WESTMINSTER
d. STREET ADDRESS 102 LIBERTY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First LUCINDA Middle V. Last HAINES
4. DATE OF DEATH Month AUG. Day 14 Year 1958
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH APRIL 21, 1880
9. AGE (In years last birthday) 78 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME EMANUEL HOLLENBAUGH
14. MOTHER'S MAIDEN NAME CATHERINE NULL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Address 102 LIBERTY MRS WM. NEWTON WESTMINSTER, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardio vascular disease — INTERVAL BETWEEN ONSET AND DEATH about 5 years
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Senility — 8 years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a). 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
none

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 19 48 to Aug. 14 19 58 that I last saw the deceased alive on Aug. 13 19 58, and that death occurred at 4 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE C. L. Billingslea M.D. ADDRESS (Street, city or town, state) Westminster, Md. DATE SIGNED 8-16-58

PHYSICIAN'S NAME (Type) C. L. Billingslea

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF AUG 17 58
22c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH CEM.
22d. LOCATION (City, town, or county) (State) WESTMINSTER MD.

23. FUNERAL DIRECTOR'S SIGNATURE David A. Bankard ADDRESS Westminster, Md.
24a. REC'D BY REGISTRAR DATE AUG 19 '58
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8942

CERTIFICATE OF DEATH

Reg. Dist. No. 08938

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Taneytown
c. LENGTH OF STAY IN 1b: 45 years.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X. Taneytown
d. STREET ADDRESS: Frederick Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Katherine — Middle: J. — Last: Hemler

4. DATE OF DEATH: Month: August — Day: 23 — Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 24, 1886

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: John W. Megee

14. MOTHER'S MAIDEN NAME: Ella Crass

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-01-3804B

17. INFORMANT — Address: Mr. Pius Hemler, Taneytown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized Arteriosclerosis — 10 yrs.
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Intertrocnanteric Fracture Rt. hip 7/6/58 (Notified Dr. J. T. Marsh-Westminster, Md.)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell on floor 903.0

20c. TIME OF INJURY: Hour: 10 o. m. p. m. — Month: 7 — Day: 6 — Year: 1958

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Taneytown Carroll Md.

21. I certify that I attended the deceased from Feb. 3, 1941 to Aug. 23, 1958, that I last saw the deceased alive on Aug. 23, 1958, and that death occurred at 10 P.M. E.S.T. from the causes and on the date stated above.

ACTUAL SIGNATURE: R. S. McVaugh, M.D. — ADDRESS (Street, city or town, state): 49 Frederick St.-Taneytown, Md. — DATE SIGNED: 8/25/58

PHYSICIAN'S NAME (Type): R. S. McVaugh

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: August 28, 1958

22c. NAME OF CEMETERY OR CREMATORY: St. Joseph's Cemetery

22d. LOCATION (City, town, or county) (State): Taneytown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Marilyn C. Fuss — ADDRESS: C.O.Fuss & Son, Taneytown, Maryland

24a. REC'D BY REGISTRAR — DATE: AUG 26 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8943

CERTIFICATE OF DEATH

Reg. Dist. No. 08939

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 mo. 18 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 24
d. STREET ADDRESS: 530 S. Streeper St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Annie — Middle: Margaret — Last: Voglesang HESELBACH

4. DATE OF DEATH: Month: August — Day: 19, — Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 20, 1870

9. AGE (In years last birthday): 88 yrs

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Conrad Voglesang

14. MOTHER'S MAIDEN NAME: Margaret Ott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.assoc.with senile brain disease with psychotic reaction. Fracture, intracapsular, right hip, femur.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1958, to August 19, 1958, that I last saw the deceased alive on August 18, 1958, and that death occurred at 3:25A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D. — ADDRESS (Street, city or town, state): Springfield Hospital — DATE SIGNED: 8/19/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8/22/58
22c. NAME OF CEMETERY OR CREMATORY: Schwartz's Cemt
22d. LOCATION (City, town, or county): BALTO. (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Hartley Miller — ADDRESS: 2334 [redacted] Jefferson St.

24a. REC'D BY REGISTRAR — DATE: AUG 20 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8944 **CERTIFICATE OF DEATH** Reg. Dist. No. 08940

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gamber, Sykesville Rt.#3
c. LENGTH OF STAY IN 1b: all of life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gamber, Sykesville, Rt. #3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First FRANCIS Middle MARION Last HOFF

4. DATE OF DEATH: Month August Day 21 Year 1958

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Oct. 21, 1876
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Dym farm
11. BIRTHPLACE (State or foreign country): Carroll Co., Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: David Hoff
14. MOTHER'S MAIDEN NAME: Martha Lockard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 219-36-0492
17. INFORMANT: Herman M. Hoff Address: Gamber, Sykesville, Rt. #3

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertensive cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: several yrs.

DUE TO
(b): generalized arteriosclerosis — II

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO
(c): senile changes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1940, 19__, to August 21, 19 58 that I last saw the deceased alive on 13 August, 19 58, and that death occurred at 1:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Liberty Road at Eldersburg — DATE SIGNED: 8.21.58

PHYSICIAN'S NAME (Type): Wm. H. Lawson, Jr., M.D. — Sykesville P.O., Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-23-1958
22c. NAME OF CEMETERY OR CREMATORY: CALVARY CEMETERY
22d. LOCATION (City, town, or county) (State): GAMBER, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: JOHN R. BYERS, WSETMINSTER, MARYLAND
24a. REC'D BY REGISTRAR DATE: AUG 25 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8945 **CERTIFICATE OF DEATH** 08941

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 564 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Henryton State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
d. STREET ADDRESS: P.O. Box 296
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Irving — Middle Elijah — Last Holloway

4. DATE OF DEATH: August 17 1958

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: January 31, 1902
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Delmar, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Elijah Holloway
14. MOTHER'S MAIDEN NAME: Sarah Hearn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16 SOCIAL SECURITY NO.: 222-05-1196
17 INFORMANT: Irving E. Holloway — Address: Delmar, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cardiovascular insufficiency — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Moderately advanced pulmonary tuberculosis

DUE TO

(c) Hypertensive cardiovascular disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from February 5, 1957, to August 17, 1958, that I last saw the deceased alive on August 17, 1958, and that death occurred at 4:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): Henryton, Maryland
DATE SIGNED

PHYSICIAN'S NAME (Type): Dr. Edgars M. Maculans, M.D. — Henryton State Hospital, Henryton, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-21-58
22c. NAME OF CEMETERY OR CREMATORY: Union Cem.
22d. LOCATION (City, town, or county) (State): Delmar, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Booker M. West
ADDRESS: Salisbury Md
24a. REC'D BY REGISTRAR DATE: AUG 19 '58
24b REGISTRAR'S SIGNATURE: Arthur S. Kraus

VS A15 (4) 15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon sheets. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8946

CERTIFICATE OF DEATH

Reg. Dist. No. 08942

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
d. STREET ADDRESS: -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James — Middle Edward — Last Horn

4. DATE OF DEATH: Month August — Day 13, — Year 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: November 5, 1875

9. AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bartender

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: - Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: 216-10-8944A

17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: Years

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.assoc.with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 21, 1958, to August 13, 1958, that I last saw the deceased alive on August 12, 1958, and that death occurred at 1:40A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 8/13/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-15-1958
22c. NAME OF CEMETERY OR CREMATORY: Woodlawn
22d. LOCATION (City, town, or county) (State): Balto

23. FUNERAL DIRECTOR'S SIGNATURE: Harry Byers
ADDRESS: 8778 Fidelity Ellicott City, Md.

24a. REC'D BY REGISTRAR DATE: AUG 25 '58
24b. REGISTRAR'S SIGNATURE: Calvin S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8925

CERTIFICATE OF DEATH

08943

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 50 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 237 E. MAIN ST.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MD. — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
d. STREET ADDRESS: 237 E. MAIN
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MAUD — Middle ESTELLE — Last HORNER

4. DATE OF DEATH: Month AUGUST — Day 18 — Year 1958

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: MARCH 30 1875

9. AGE (In years last birthday): 83 yrs

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: ALFRED ALGIRE

14. MOTHER'S MAIDEN NAME: CAROLINE HOUCK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: HELEN HORNER — Address 237 E. MAIN WESTMINSTER, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 5 DAYS

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) PAPILLOCARCINOMATOSIS URINARY BLADDER — 14 MONTHS

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from NOVEMBER, 1957, to AUGUST, 1958, that I last saw the deceased alive on AUGUST 15, 1958, and that death occurred at 8 00 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Daniel J Wellner M.D. — ADDRESS (Street, city or town, state): 19 N. CHURCH ST, WESTMINSTER — DATE SIGNED: 8/18/58

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: AUG. 21 58

22c. NAME OF CEMETERY OR CREMATORY: METHODIST CEM.

22d. LOCATION (City, town, or county) (State): FINKSBURG, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: David C. Bankard — ADDRESS: Westminster, Md.

24a. REC'D BY REGISTRAR DATE: AUG 22 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8947

CERTIFICATE OF DEATH

08944
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 4yrs 1mo
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 311
d. STREET ADDRESS: 615 S Ponca St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Virginia — Middle Kastellorefos — Last
4. DATE OF DEATH: Month 8 — Day 30 — Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 1880
9. AGE (In years last birthday): 78 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Greece
12. CITIZEN OF WHAT COUNTRY? unknown

13. FATHER'S NAME: Gus Sevdalis
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Nick A. Kastelloregos — Address 615 Ponca St. Baltimore 24

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Functional Disease of Heart (Arrhythmia) — years
DUE TO (c): Generalized Arteriosclerosis — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CBS associated with disturbance of growth, metabolism of nutrition, with senile brain disease with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-18-, 1954, to 8-30, 1958, that I last saw the deceased alive on 8-30-, 1958, and that death occurred at 10:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Elisabeth M. Knopp M.D. — ADDRESS (Street, city or town, state): Spring field State Hosp. — DATE SIGNED: 8-30-58

PHYSICIAN'S NAME (Type): Elisabeth M. Knopp — Sykesville, Maryland

22a. BURIAL CREMATION REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-2-58
22c. NAME OF CEMETERY OR CREMATORY: Greek
22d. LOCATION (City, town, or county) (State): Balto. Md

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Lambros Inc 440 E. North Ave
24a. REC'D BY REGISTRAR DATE: 9/2/58
24b. REGISTRAR'S SIGNATURE: Richard L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08945

8948

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 16yrs.4mos.9days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1005 N. Charles St. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Aloysius — Middle H. — Last Kennedy

4. DATE OF DEATH: Month August — Day 13, — Year 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 29, 1894

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland — Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Thomas Kennedy

14. MOTHER'S MAIDEN NAME: J. Winifred O'Donnell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO: None

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days
491X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Mental Deficiency without psychosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 27, 1955, to August 13, 1958, that I last saw the deceased alive on August 13, 1958, and that death occurred at 7:00P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Julian Radcykowycz M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 8/13/58

PHYSICIAN'S NAME (Type): Julian Radcykowycz, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/16.58

22c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tucker — ADDRESS: Hagerstown, Md.

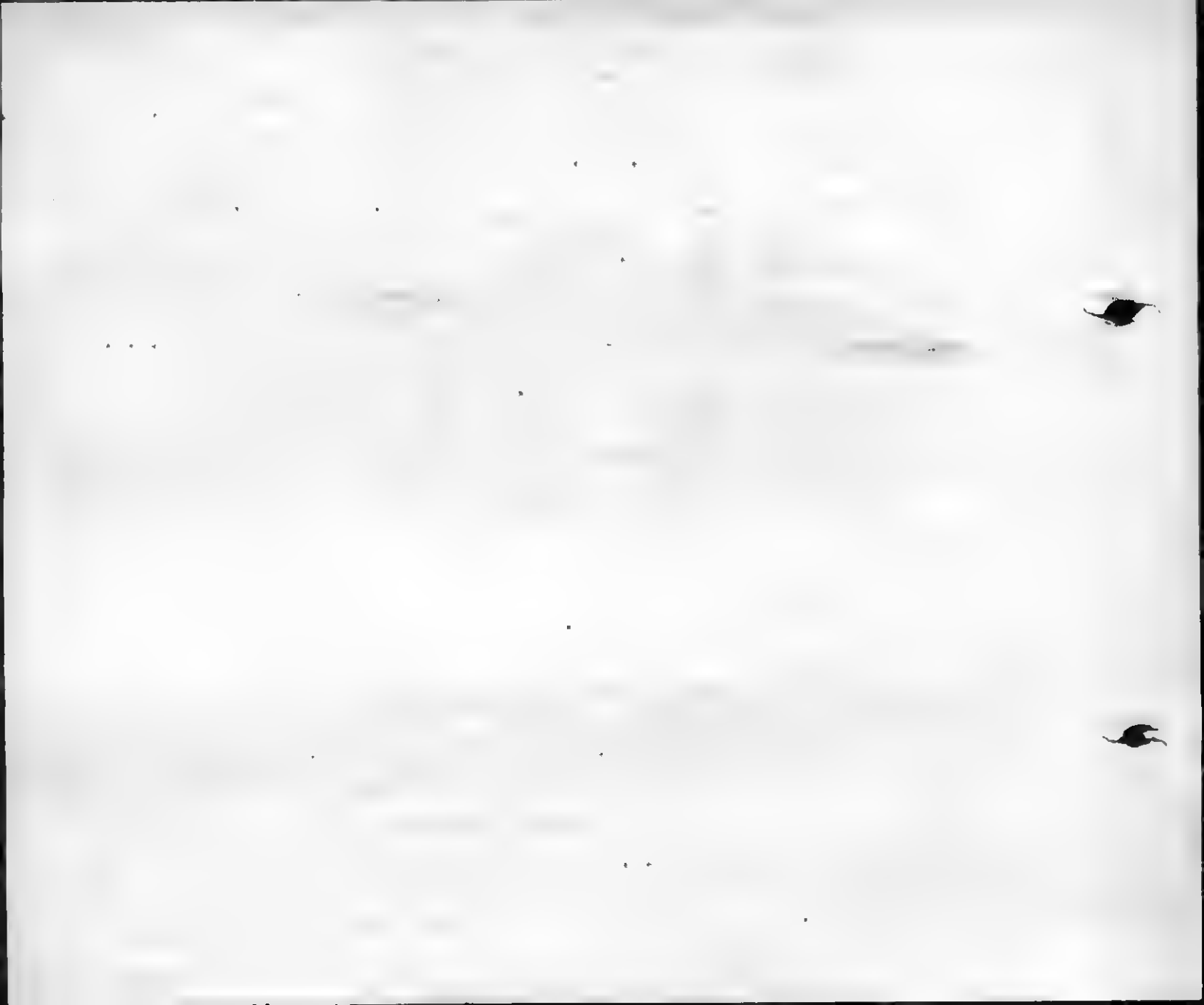
24a. REC'D BY REGISTRAR — DATE: AUG 18 '58

24b REGISTRAR'S SIGNATURE: Cletus L. Keane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8949

CERTIFICATE OF DEATH

Reg. Dist. No. 08946

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Nr. Westminster
c. LENGTH OF STAY IN 1b: 50 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Westminster, R.D.2 (Myers District)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Nr. Westminster
d. STREET ADDRESS: Westminster, R.D.2 (Myers District)
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Lewis — Middle: Henry — Last: Kirkhoff

4. DATE OF DEATH: Month: August — Day: 4 — Year: 19 58

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 8/28/1885
9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming, Retired
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Lewisburg, Ohio.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William A. Kirkhoff
14. MOTHER'S MAIDEN NAME: Sarah Lookingbill.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs Lewis H Kirkhoff (Address) Mrs. Lewis H. Kirkhoff, Westminster, Md. R.D.2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial insufficiency ischemia — INTERVAL BETWEEN ONSET AND DEATH: 20 minutes
443X
DUE TO (b): Arteriosclerotic cardio-vascular disease — 15 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertension
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour, a. m. / p. m., Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February, 19 57, to August, 19 58, that I last saw the deceased alive on August 3, 19 58, and that death occurred at 8:30A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Leah Maitland M.D. — ADDRESS (Street, city or town, state): Littlestown, Pa — DATE SIGNED: 8/4/58
PHYSICIAN'S NAME (Type): LEAH MAITLAND — LITTLESTOWN, PA

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/6/58
22c. NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery
22d. LOCATION (City, town, or county) (State): Silver Run, Carroll Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Richard A. Little — ADDRESS: Littlestown, Pa.
24a. REC'D BY REGISTRAR DATE: AUG 6 '58
24b. REGISTRAR'S SIGNATURE: W. H. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8950

CERTIFICATE OF DEATH

08947

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 35yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: City 311
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Isabella — Middle: K. — Last: Lautenberger
4. DATE OF DEATH: Month: August — Day: 17 — Year: 1958
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-29-1883
9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Harry J. Pirre
14. MOTHER'S MAIDEN NAME: Isabella McCoy
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 212-03-3147
17. INFORMANT: Christian H Lautenberger — Address: 3323 Spaulding Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 480.0 — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Malignant Hypertension — 3 Weeks
DUE TO (c): arterio sclerotic Heart Disease — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Involutional Psychotic Reaction

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from July 31, 1958, to August 17, 1958, that I last saw the deceased alive on August 17, 1958, and that death occurred at 9:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Elisabeth Knopp M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital Sykesville, MD — DATE SIGNED: 8-17-58

PHYSICIAN'S NAME (Type): Elisabeth Knopp

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-20-1958
22c. NAME OF CEMETERY OR CREMATORY: Druid Ridge
22d. LOCATION (City, town, or county) (State): Balto. Md

23. FUNERAL DIRECTOR'S SIGNATURE: Loring Byers — ADDRESS: 8728 Liberty Road. Randallstown.
24a. RECEIVED BY REGISTRAR DATE: AUG 25 '58
24b REGISTRAR'S SIGNATURE: Carlton S. Knaus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8951

CERTIFICATE OF DEATH

68948

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Finksburg

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RD #1 Box 441

d. STREET ADDRESS: RD # 1 Box 441

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA Middle AGNES Last Leister (Leister)

4. DATE OF DEATH: Month August Day 3 Year 1958

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 23, 1867

9. AGE (In years last birthday): 90 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: James Read

14. MOTHER'S MAIDEN NAME: Eliza Jane ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO — (If yes, give war or dates of service): NO

16 SOCIAL SECURITY NO.: NO

17 INFORMANT: E. Morgan Leister — Address: RD #1 Box 441 Finksburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac insufficiency — 4 w
DUE TO (b): Arteriosclerotic Cardio Vascular Renal Dis — years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1 wk

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ... a. m. p. m. Month ... Day ... Year ... 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ..., 1958, to 8/3, 1958, that I last saw the deceased alive on 8/3, 1958, and that death occurred at 4:15 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: G Allen Mouton, M.D. — ADDRESS (Street, city or town, state): 148 W Main St Westminster — DATE SIGNED: 8/5/58

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/6/58

22c. NAME OF CEMETERY OR CREMATORY: Loudon Park

22d. LOCATION (City, town, or county) (State): Baltimore Md.

23 FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: John T. Stansbury 6411 Windsor Mill Rd

24a. REC'D BY REGISTRAR — DATE: AUG 5 '58

24b REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08949

8952

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 6yrs.3mos.27days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Timothy — Middle Joseph — McAuliffe (McCauliffe)
4. DATE OF DEATH: Month August — Day 26, — Year 19 58

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-6-1883
9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY? Unknown

13. FATHER'S NAME: Daniel McAuliffe
14. MOTHER'S MAIDEN NAME: Catherine McDonald

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO: -
17. INFORMANT Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Infarction of myocardium due to coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes.

4 .1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO: Pulmonary tuberculosis, far advanced, inactive — Years

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenia, paranoid type.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from October 20, 1954 to August 26, 1958 that I last saw the deceased alive on August 25, 1958, and that death occurred at 6:45A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M D
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 8/26/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 8-28-58
22c. NAME OF CEMETERY OR CREMATORY: New Cathedral
22d. LOCATION (City, town or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Lenard J. Luck 5305 Harford.
24a. REC'D BY REGISTRAR DATE: AUG 28 '58
24b. REGISTRAR'S SIGNATURE: Evelyn L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8953 — 09657 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Manchester Md RD 1
c. LENGTH OF STAY IN 1b: 60 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution· Residence before admission)
a. STATE: Md. — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Manchester
d. STREET ADDRESS: RD #1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First FRANK — Middle GEORGE — Last MECKLEY
4. DATE OF DEATH: Month Aug. — Day 15 — Year 1958
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Aug 26 1884
9. AGE (In years last birthday): 73 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Manheim Township, Pa.
12. CITIZEN OF WHAT COUNTRY?: U.S.
13. FATHER'S NAME: David Meckley
14. MOTHER'S MAIDEN NAME: Catherine (Unknown)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220-24-2594
17. INFORMANT: Address: Dillie Zepp Meckley Manchester Md Rd 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute cardiac Dilitation	Instant
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Congestive Heart Failure	8 mo.
DUE TO (c)	Arterio-Sclerotic Coronary Disease	2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 19 58, to August 15, 19 58, that I last saw the deceased alive on August 10, 19 58, and that death occurred at 11:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: M.C. Porterfield M.D. — ADDRESS (Street, city or town, state): Hampstead, Md. — DATE SIGNED: 8/16/58

PHYSICIAN'S NAME (Type): M.C. Porterfield, M.D. — Hampstead, Md. — 8/16/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 18, 1958
22c. NAME OF CEMETERY OR CREMATORY: St Jacobs Stone Church
22d. LOCATION (City, town, or county) (State): Brodbeck RD York Co. Pa

23. FUNERAL DIRECTOR'S SIGNATURE & ADDRESS: Geo. D. Keefer & Son Glen Rock, Pa.
24a. RECD BY REGISTRAR DATE: AUG 19 58
24b. REGISTRAR'S SIGNATURE: Edwin L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8954 — Reg. Dist. No. 08950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural : SYKESVILLE
c. LENGTH OF STAY IN 1b: 5 years.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland. b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring.
d. STREET ADDRESS: 8407 16th. St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert Whitney — Middle: [redacted] — Last: MILLER SR.

4. DATE OF DEATH: Month: August — Day: 1 — Year: 1958

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11-20-90

9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accounting Div. Army & NAVY [redacted] U.S.Gov't

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Colorado

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard F. Miller

14. MOTHER'S MAIDEN NAME: RACHEL STROTHER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): Army 1910-1925

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Records of Springfield State Hospital. Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): [redacted] a Pyelonephritis, bilateral

DUE TO (b): Pneumonia.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome ass. c CNS syphilis, meningoencephalitis and psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 1955, to August 1, 1958, that I last saw the deceased alive on August 1, 1958, and that death occurred at 11 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter Knopp M.D. ADDRESS (Street, city or town, state): Springfield State Hospital DATE SIGNED

PHYSICIAN'S NAME (Type): Walter Knopp, M.D. Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8/6/58

22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NAT'L. CEMETERY

22d. LOCATION (City, town, or county) (State): ARLINGTON, VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey ADDRESS: Silver Spring Md.

24a. REC'D BY REGISTRAR DATE: AUG 7 '58

24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8955 — Reg. Dist. No. 08951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Balto. City

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville

c. LENGTH OF STAY IN 1b: 2yrs. 3mos. 2days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 12

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

d. STREET ADDRESS: 1212 Walters Ave.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frieda — Middle: Ermine Wieman — Last: MOORE

4. DATE OF DEATH: Month: August — Day: 18, — Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 21, 1890

9. AGE (In years last birthday): 67 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Public Health Nurse

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Canada

12. CITIZEN OF WHAT COUNTRY? Unknown

13. FATHER'S NAME: Levi (Wieman) WYMAN

14. MOTHER'S MAIDEN NAME: Amanda Wieman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT — Address: Springfield State Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years

420.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. assoc. with presenile brain disease with psychotic reaction. Decubitus ulcer on back.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 16, 1956, to August 18, 1958, that I last saw the deceased alive on August 18, 1958, and that death occurred at 6:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 8/19/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D. — Sykesville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 8-21-58

22c. NAME OF CEMETERY OR CREMATORY: London Park

22d. LOCATION (City, town or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE: Leonard J. Luck — ADDRESS: 1305 Harford

24a. REC'D BY REGISTRAR DATE: AUG 21 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8956

CERTIFICATE OF DEATH

Reg. Dist. No. 08952

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville (Rural)
c. LENGTH OF STAY IN 1b: 15 y. 2 m. 13
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): d. Unknown
d STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Bessie; Middle: ; Last: Motter

4. DATE OF DEATH: Month: August; Day: 22; Year: 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 15, 1877
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS: Months; Days; Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John C. Motter
14. MOTHER'S MAIDEN NAME: Effie Marken

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Springfield State Hospital Record — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Mins.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Cardiovascular Disease — Years

DUE TO (c): Generalized Arteriosclerosis — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Paranoid state

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour; a. m. p. m.; Month; Day; Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 1, 1955, to August 22, 1958, that I last saw the deceased alive on August 21, 1958, and that death occurred at 9:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Elisabeth M. Knopp M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 8/22/58

PHYSICIAN'S NAME (Type): Elisabeth M. Knopp, M. D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 8-25-58
22c. NAME OF CEMETERY OR CREMATORY: Mt Olivet
22d LOCATION (City, town, or county) (State): Frederick md

23. FUNERAL DIRECTOR'S SIGNATURE: Cherry Chase Funeral Home — ADDRESS: 5103 nw 16th ave Washington D.C.
24a. REC'D BY REGISTRAR DATE: AUG 27 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be attached with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8957

CERTIFICATE OF DEATH

Reg. Dist. No. 08953

1. PLACE OF DEATH
a. COUNTY ~~Carroll~~ ~~Springfield State Hosp.~~ MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Md b. COUNTY Baltimore city 311

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore ✓

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hosp.

d. STREET ADDRESS 3202 Moravia Ave, Balt 14, Md

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Louise	Smith	Murkey		8	17	1958

5 SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.
femal	white		11/21/75	82 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
NONE	dependent	USA BALTO.	

13 FATHER'S NAME ? Schmidt

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Son. 3006 Beverley Rd Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branchopneumonia due to undetermined cause — INTERVAL BETWEEN ONSET AND DEATH

4 2 0.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Senile atrophy, and marasm — 7 days

DUE TO (c) Arteriosclerotic heart desease

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

4 9 1 X

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-9, 1958, to 8-17, 19____, that I last saw the deceased alive on 8-16-58, 19____, and that death occurred at 8,45 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE Ellis S Margholin M.D. ADDRESS (Street, city or town, state) DATE SIGNED

PHYSICIAN'S NAME (Type) Ellis S .Margholin

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	AUG. 20 58	OAK LAWN	BALTO. MD.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
P.A. Heemann 6067 HARFORD RD	AUG 20 '58	Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper sheets. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8958

CERTIFICATE OF DEATH

08954
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: 23 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 930 E Main Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILBERT — Middle LINCOLN — Last ORNDORFF

4. DATE OF DEATH: Month 8 — Day 1 — Year 1958

5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/6/1919
9. AGE (In years last birthday): 39 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (State or foreign country): USA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph H. Orndorff
14. MOTHER'S MAIDEN NAME: Mary Sheets

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-16-0228
17. INFORMANT: Record, Springfield State Hospital, Sykesville — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Old and New Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Arteriosclerotic heart disease with angina pectoris year?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute Brain Syndrome associated with metabolic disturbance (uremia)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18): ----
20c. TIME OF INJURY: Hour ---- a. m. p. m. — Month, Day, Year ---- 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ------
20f. (City or town) (County) (State): -- ------

21. I certify that I attended the deceased from 7/8, 1958, 8/1, 1958, that I last saw the deceased alive on 8/1, 1958, and that death occurred at 12:55 P dst M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Yasuo Takahashi M.D. — ADDRESS (Street, city or town, state): Sykesville, Maryland — DATE SIGNED: 8/1/58
PHYSICIAN'S NAME (Type): Yasuo Takahashi, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/4/58
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel Inc. — ADDRESS: 1601 Penna. Ave. Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: AUG 4 '58
24b. REGISTRAR'S SIGNATURE: W. Heduck

Wm. A. Horst U-Dr.

Old and New Myocardial Infarct

1

FOR STATE HEALTH DEPT.

+ mo 18-21 Film

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8926 Item 7 Film 232 8-11-5F et

08955 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 7 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Court Place

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 Westminster
d. STREET ADDRESS: Court Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MARY — Middle JANE — Last RAILING

4. DATE OF DEATH: Month August — Day 4 — Year 19 58

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: APRIL 5 1895

9. AGE (In years last birthday): 63 yrs

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE-WIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): SOMERSET Co, PENNA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DONALD CRAIG

14. MOTHER'S MAIDEN NAME: GRACE TAIT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: MR W.E. RAILING, Address PENNSGROVE NEW JERSEY

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Barbiturate Poisoning — INTERVAL BETWEEN ONSET AND DEATH

970.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Ingested barbiturates

20c. TIME OF INJURY: Hour — o m / p m — Month, Day, Year: 8/4/58

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Westminster — (County): Carroll — (State): Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Paul F. Guerin M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 8/5/58

EXAMINER'S NAME (Type): Paul F. Guerin, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: AUG. 7, 58

22c. NAME OF CEMETERY OR CREMATORY: WESTMINSTER CEM.

22d. LOCATION (City, town, or county): WESTMINSTER, Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr. — ADDRESS: Westminster, Md.

24a. REC'D BY REGISTRAR: DATE AUG 7 '58

24b. REGISTRAR'S SIGNATURE: [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 4 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8959 Item 1 Filed 8-11-58 at

CERTIFICATE OF DEATH

08956

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll County — MARYLAND
Zinger Boarding Home
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Bal...
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 03x-2
d. STREET ADDRESS 111 Reisterstown Road #8
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First FREDERICK Middle F. Last RONNENBERG
4. DATE OF DEATH Month August Day 3 Year 1958
5. SEX M
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Oct. 22, 1874
9. AGE (In years last birthday) 83
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY Hughes Lumber Co.
11. BIRTHPLACE (State or foreign country) Catonsville, Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME ? Ronnenberg
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Yes
17. INFORMANT Address Miami, Florida
Mrs. Dorothy Denny-1023 Southwest 6th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Thrombosis, Arteriosclerosis.	
DUE TO		1957
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Ephysema- Bronchitis -	
DUE TO (c)		3 Aug 58
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 57 to 3 Aug, 19 58, that I last saw the deceased alive on 3 August, 19 58, and that death occurred at 5:30 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE Howard E. Hall M.D. ADDRESS (Street, city or town, state) Sykesville, Md DATE SIGNED 3 Aug 58

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8/6/58
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery
22d. LOCATION (City, town, or county) (State) Pikesville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons ADDRESS Balto 17, Md.
24a. REC'D BY REGISTRAR DATE AUG 5 '58
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57


1

FOR STATE HEALTH DEPT.

Item 20h Film 233 [illegible]

8960

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 8957

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millers
c. LENGTH OF STAY IN Tb: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): River Valley Ranch

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 5 Chain-O-Hill, Markley Pk.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First THOMAS; Middle LEROY; Last RUSSELL

4. DATE OF DEATH: Month August; Day 8; Year 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 16, 1914

9. AGE (In years last birthday): 44 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Nat'l. Plastic

11. BIRTHPLACE (State or foreign country): St. Mary's Co., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William T. Russell

14. MOTHER'S MAIDEN NAME: Laura M. Shorter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W. II

16. SOCIAL SECURITY NO.: 212-05035

17. INFORMANT: Mrs. Elsie M. Russell — Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Compression of spinal cord
DUE TO (b): Fracture of fifth cervical vertebra
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 902.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Dived into shallow water

20c. TIME OF INJURY: Hour; o. m / p. m.; Month, Day, Year: Aug. 8, 1958

20d. INJURY OCCURRED: While at work ☐ Not while at work ☑

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): River Valley Ranch

20f. (City or town): Millers (County): Carroll (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 8/9/58

EXAMINER'S NAME (Type): Charles S. Petty, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-13-58

22c. NAME OF CEMETERY OR CREMATORY: Meadowridge Mem. Park

22d. LOCATION (City, town, or county) (State): Howard Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: T. Livingston — ADDRESS: Glen Burnie, Maryland

24a. REC'D BY REGISTRAR (Date): AUG 12 1958

24b. REGISTRAR'S SIGNATURE: Christine S. Reaves

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 4 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After certification has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08958

8961

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: 1yr.4mos.13days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Route #1, Hagerstown
d. STREET ADDRESS: ---
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Clayton — Last: RUTH

4. DATE OF DEATH: Month: August — Day: 3 — Year: 1958

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: February 9, 1878

9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stock clerk - ret.

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: William C. Ruth

14. MOTHER'S MAIDEN NAME: Mary A. Sprecker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 214-09-4313

17. INFORMANT: Records of Springfield State Hospital
Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Old and new myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: yrs. - hours
4.20.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis — years
DUE TO (c): ---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY ~~MEDICAL~~ EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): ---

20c. TIME OF INJURY: Hour: o. m. / p. m. ---; Month, Day, Year: ---, 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---

20f. (City or town) (County) (State): ---

21. I certify that I attended the deceased from March 21, 1957, to August 3, 1958, that I last saw the deceased alive on August 3, 1958, and that death occurred at 8:00 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter Knopp M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 8-4-58

PHYSICIAN'S NAME (Type): Walter Knopp, M. D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/7/1958
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county): Hagerstown, (State): Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home
R. Franklin Rouzer
ADDRESS: Hagerstown, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 11 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08959

8962

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 mo. 9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: 627 E. 33rd Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ethel Middle Margaret Last Schuncke

4. DATE OF DEATH: Month August Day 6, Year 19 58

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 30, 1901
9. AGE (In years last birthday): 57 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife - Clerk
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Powell
14. MOTHER'S MAIDEN NAME: Ruth Pierce

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: -
17. INFORMANT Address: Springfield State Hospital, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days
581.0
DUE TO (b): Acute pyelonephritis — Weeks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): Portal cirrhosis of the liver — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. of unknown cause.
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour ___ a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1958, to August 6, 1958, that I last saw the deceased alive on August 6, 1958, and that death occurred at 11:20 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Francisco Piqueras, M.D. M.D. — ADDRESS (Street, city or town, state): Sykesville, Maryland — DATE SIGNED: August 7, 1958

PHYSICIAN'S NAME (Type): Francisco Piqueras, M.D. — Springfield State Hospital

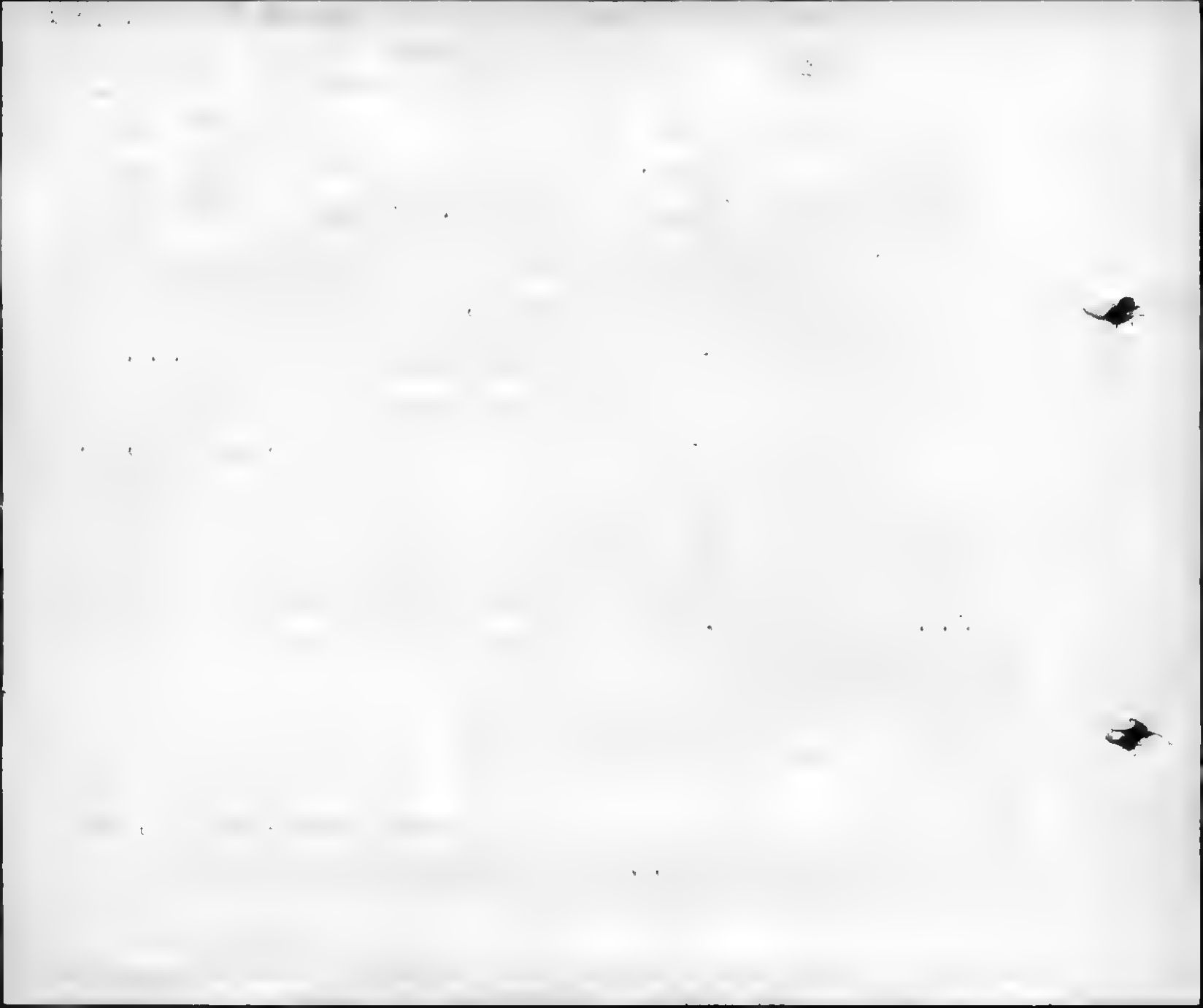
22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/9/58
22c. NAME OF CEMETERY OR CREMATORY: Greenmount
22d LOCATION (City, town, or county) (State): Balto.

23. FUNERAL DIRECTOR'S SIGNATURE: Ritie Wiedefeld — ADDRESS: 900 E. Baltimore St.

24a. REC'D BY REGISTRAR DATE: AUG 8 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08960

8963

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Carroll — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): City Sykesville — c. LENGTH OF STAY IN 1b: 4y,7 mo,8 days — d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hosp. — Sykesville, Springfield St. Hosp. MARYLAND

2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission) a. STATE: Md — b. COUNTY: Md, Baltimore — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore — d. STREET ADDRESS: 4423 Buena vista Ave, Balt. 11 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Walter	Mason	SHEELEY	8	17	1958

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS: Hours	Min.
male	white		7-13-01	57 yrs				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bricklayer	Contractor	Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Sheeley (dec'd)	Ida Sheeley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	218-32-3182	Mrs. Mildred N. Sheeley 414 Aigburth Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pneumonia, Right lower lobe. — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (b) Pyelonephritis, R. Kidney & calculus. (c) Pick's disease of the brain (possible).

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m p. m. Month Day Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			

21. I certify that I attended the deceased from 8/13/58, 19____, to 8/16/58 19____, that I last saw the deceased alive on 8/16/58, 19____, and that death occurred at 12:50 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Edmund Lusthaus M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED 8/17/58.

PHYSICIAN'S NAME (Type) Edmund Lusthaus.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Aug. 20, 1958	Druid Ridge	Pikesville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Burgee Funeral Home 3631 Falls Road Horace F. Burgee	AUG 19 '58	Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 232 8-13-3 at

CERTIFICATE OF DEATH

8964 — 08961 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2 mo. 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City, 2420 Edmondson Ave. 3 V. 1-4
d. STREET ADDRESS: Methodist Home for Aged 2211 N. Rogers Ave.
IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First [illegible] Middle X ALICE E. Last SHOCKLEY

4. DATE OF DEATH: Month August Day 7 Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 29, 1869
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Seamstress
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland — Snow Hill
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Mumford
14. MOTHER'S MAIDEN NAME: [illegible] Eleanor Godfrey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: -
17. INFORMANT Address: Springfield State Hospital, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Mesenterial thrombosis due to arteriosclerosis of mesenterial artery. — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
DUE TO
(b) Chronic rheumatic heart disease with mitral insufficiency. — years
DUE TO
(c) General arteriosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1958, to August 7, 1958, that I last saw the deceased alive on August 7, 1958, and that death occurred at 12:00P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Francisco Piqueras, M.D. ADDRESS (Street, city or town, state): Sykesville, Maryland, DATE SIGNED: August 7, 1958

PHYSICIAN'S NAME (Type): Francisco Piqueras, M.D. Springfield State Hospital

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/9/58
22c. NAME OF CEMETERY OR CREMATORY: Meadowridge Mem. Pk. Cem.
22d LOCATION (City, town, or county) (State): Baltimore, Maryland

FUNERAL DIRECTOR'S SIGNATURE: Wm J. Jackson & Sons. ADDRESS: North & Penna Ave Balto. Md.
24a. REC'D BY REGISTRAR DATE: AUG 8 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08962

CERTIFICATE OF DEATH

8965

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy on this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY: CARROLL — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL, WESTMINSTER RURAL ROUTE

LENGTH OF STAY (in this place): LIFE

HOSPITAL OR INSTITUTION OR STREET ADDRESS: SAND HILL ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: MARYLAND COUNTY: CARROLL

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL, WESTMINSTER, MD.

STREET ADDRESS (If rural give location): FINKSBURG, RD#1, MD.

3. NAME OF DECEASED (Type or Print): (First) LOTTIE (Middle) MAE (Last) SLORP

4. DATE OF DEATH (Month) AUG. (Day) 2 (Year) 1958

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
F.	W.	single	AUG 25 1895	62 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): FINKSBURG, RD#1, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN SLORP

14. MOTHER'S MAIDEN NAME: MINERVA TAYLOR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: JOHN L. SLORP, FINKSBURG, MD. RD#1

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A): Uremic Nephritis — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSE(S) DUE TO (B): Myocarditis (chr) Hypertension

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C): Diabetes

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 7, 19 58, to Aug 2, 19 58, that I last saw the deceased alive on Aug 2, 19 58, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

SIGNATURE, M.D.: W. C. Smith — ADDRESS (Street, city, town, state): 103 E Main Westminster Md — DATE SIGNED: Aug 3

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	AUG. 5, 1958	BETHEL CEMETERY	CARROLLTON CARROLL Co MD.

24. REC'D BY REGISTRAR — DATE: AUG 5 58 — REGISTRAR'S SIGNATURE:

25. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr. — ADDRESS: Westminster Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08963

8966

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Old Westminster Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg
d. STREET ADDRESS: Old Westminster Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anthony; Middle: ; Last: Smith

4. DATE OF DEATH: Month: Aug. Day: 21 Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Apr. 10, 1872

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Frederick Co., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Dennis Smith

14. MOTHER'S MAIDEN NAME: Long

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. C.C. Williams, Finksburg, Md.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 min.
420.1
DUE TO
(b): Arteriosclerotic C.-V. Disease — 5 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Cystitis due to Prostatic Hypertrophy

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): none

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none

20c. TIME OF INJURY Hour a. m. p. m.: Month, Day, Year: none 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town) (County) (State):

21. I certify that I attended the deceased from 4-3-53, 19____, to 8-21-58, 19____, that I last saw the deceased alive on 8-19-58, 19____, and that death occurred at 11:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: D. D. Caples M.D.
ADDRESS (Street, city or town, state): 6 Hanover Rd.
DATE SIGNED: 8-22-58

PHYSICIAN'S NAME (Type): D. D. Caples, M. D. Reisterstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 24, 1958
22c. NAME OF CEMETERY OR CREMATORY: Bethesda Methodist
22d. LOCATION (City, town, or county) (State): Browningsville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Olin L. Molesworth
ADDRESS: Damascus, Md.

24a. REC'D BY REGISTRAR DATE: AUG 25 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After [illegible] certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8967 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

018964

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 4 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

1. PLACE OF DEATH — a. COUNTY: CARROLL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SYKESVILLE
   c. LENGTH OF STAY IN 1b: 2 MOS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): LIBERTY ROAD RT 91

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: BALTIMORE
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TOWSON
   d. STREET ADDRESS: 18 GUN POWDER RD
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First ERWIN Middle HAMILTON Last SQUIRES OR ERWIN

4. DATE OF DEATH: Month Aug Day 19 Year 1958

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: DEC 6 1878

9. AGE (In years last birthday): 79 yrs.
   IF UNDER 1 YEAR: Months ___ Days ___
   IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED ENGINEER

10b. KIND OF BUSINESS OR INDUSTRY: CENTURY THEATRE

11. BIRTHPLACE (State or foreign country): WARREN PA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE SQUIRES

14. MOTHER'S MAIDEN NAME: ELLA HYATT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
   (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: 215-10-4372

17. INFORMANT — Address: CHAROLOTTE AUSTIN 18 GUNPOWDER RD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: Unk.

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour ___ a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh — M D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): JAMES T. MARSH

DATE SIGNED: 8/19/58

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: AUG 23 58

22c. NAME OF CEMETERY OR CREMATORY: SCANDIA CEMETERY

22d. LOCATION (City, town, or county): SCANDIA (State): PENNA.

23. FUNERAL DIRECTOR'S SIGNATURE: Ruppel Bro. — ADDRESS: 7110 BELAIR RD

24a. REC'D BY REGISTRAR — DATE: AUG 25 '58

24b. REGISTRAR'S SIGNATURE: Catherine E. Kraus

VS. A15ME
BM 2/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8968 — Reg. Dist. No. 08965

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 mo. 28 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Damascus
d STREET ADDRESS: -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Augustus — Middle Riggs — Last Stackhouse

4. DATE OF DEATH: Month August — Day 23, — Year 19 58

5 SEX: Male

6. COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: September 24, 1864

9 AGE (In years last birthday): 93 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS: Hours | Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Hammond Stackhouse

14. MOTHER'S MAIDEN NAME: Emily Burdette

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: years
I420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. assoc. with senile brain disease with psychotic reaction.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from June 25, 1958, to August 23, 1958, that I last saw the deceased alive on August 22, 1958, and that death occurred at 2:20A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 8/23/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8-26-58
22c. NAME OF CEMETERY OR CREMATORY: Stackhouse Family Cemetery
22d. LOCATION (City, town, or county) (State): Howard Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. M. Waltz Jr.
ADDRESS: Winfield Md.

24a. REC'D BY REGISTRAR DATE: AUG 26 '58
24b. REGISTRAR'S SIGNATURE: Irvin S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8969

CERTIFICATE OF DEATH

Reg. Dist. No. 08966

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pullen Nursing Home

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodlawn
d. STREET ADDRESS: 6714 Meekins Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles Middle E. Last Trott

4. DATE OF DEATH: Month 8 Day -23 Year 1958

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 27, 1880
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired, Millwork
10b. KIND OF BUSINESS OR INDUSTRY: Melville Co.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 216.10.4395
17. INFORMANT: A William F. Trott Address: 6714 Meekins Ave. 7

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar pneumonia Bilateral — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO
(b): Cardiac failure — 2 days
DUE TO
(c): Senile City

440 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-17, 1958, to 8-23, 1958, that I last saw the deceased alive on 8-23, 1958, and that death occurred at 11:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Bertrand R Gau M.D.
ADDRESS (Street, city or town, state): 37 Central Ave
DATE SIGNED:
PHYSICIAN'S NAME (Type): Bertrand R. GAU SYKESVILLE Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/26/58
22c. NAME OF CEMETERY OR CREMATORY: New Oakland
22d. LOCATION (City, town, or county) (State): Sykesville Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J.T.Stansbury 6411 Windsor Mill Rd. 7
24a. REC'D BY REGISTRAR DATE AUG 26 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the registrar's certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8970

CERTIFICATE OF DEATH

Reg. Dist. No. 68967

M

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2 mos.12 days
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2910 McElderry St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Theresa — Middle Felicia — Last WESTERFIELD

4. DATE OF DEATH: Month August — Day 3, — Year 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 10, 1918

9. AGE (In years last birthday): 39 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

I

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days
491X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenia, catatonic type. Decubitus ulcers

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 21, 1958 to August 3, 1958 that I last saw the deceased alive on August 3, 1958 and that death occurred at 1:30P M, from the causes and on the date stated above.

SIGNATURE: Edmund Lusthaus M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 8/4/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8/6/58
22c. NAME OF CEMETERY OR CREMATORY: BALTIMORE CEMT
22d LOCATION (City, town, or county): BALTIMORE (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: C. F. Hoffmann — ADDRESS: 3218 Hudson St.

24a. REC'D BY REGISTRAR DATE: AUG 6 '58

24b REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08968

8971

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
c. LENGTH OF STAY IN 1b: 8 years, 21days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived If institutional residence before admission): a. STATE MD b. COUNTY Aberdeen, HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen
d. STREET ADDRESS: 502 S. Phila. Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Anna Middle Marie Last WHEELER
4. DATE OF DEATH: Month 8 Day 18 Year 1958
5. SEX: fem.
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/27/21
9. AGE (In years last birthday): 36 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: J.Albert Wheeler
14. MOTHER'S MAIDEN NAME: Marie Colgan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) -
16. SOCIAL SECURITY NO. -
17. INFORMANT Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral bronchopneumonia
491X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH: Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Mental Deficiency without psychosis, imbecile level, epilepsy, right brachial plexis paralysis, due to birth injury, tumor, left hemisphere, cerebellum.
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from October 20, 1954, to August 18, 1958, that I last saw the deceased alive on August 17, 1958, and that death occurred at 5:00A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D
ADDRESS (Street, city or town, state): Springfield Hospital
DATE SIGNED: 8/18/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D. Sykesville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/20/58
22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial
22d. LOCATION (City, town, or county) (State): Bel Air, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Tanning
ADDRESS: Aberdeen, Md.
24a. REC'D BY REGISTRAR DATE: AUG 21 '58
24b. REGISTRAR'S SIGNATURE: Clinton J. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1

FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS. ATSME
8M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8972 Items 3,13 Film 233 9-5-5 et

08969

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Carroll
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Ridgeville
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland
b. COUNTY Cumberland
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrill 02 X-2
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Diane Middle May Lost WHITNEY
4. DATE OF DEATH Month August Day 28 Year 1958
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH May 4 1947
9. AGE (If under last birthday) 11 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student
10b. KIND OF BUSINESS OR INDUSTRY Grade school
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edwin K. Whitney
14. MOTHER'S MAIDEN NAME Grace May Preston Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO —
17. INFORMANT Grace May Preston Address Gambrill, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fracture Base of Skull
316 x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Pulled out in front of truck
20c. TIME OF INJURY Month, Day, Year Hour 1:30 p.m. 8/28 1958
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ridgeville Rt 40
20f. (City or town) Ridgeville (County) Carroll (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE E.O. Thomas M.D.
EXAMINER'S NAME (Type) E.O. Thomas
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED August 28, 1958

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9-2-58
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery
22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE
HOPPING FUNERAL HOME
ADDRESS Annapolis, Maryland

24a. REC'D BY REGISTRAR DATE SEP 4 '58
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8973

CERTIFICATE OF DEATH

Reg. Dist. No. 08970

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 4 mos. 13 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 527 Dale Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Gertrude May Shelley Middle Last WITHERS

4. DATE OF DEATH: Month August Day 22, Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: January 19, 1881
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Shelley
14. MOTHER'S MAIDEN NAME: Mary Blanche -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years
420.0
DUE TO
(b): Generalized arteriosclerosis — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.assoc.with cerebral arteriosclerosis with psychotic reaction. Diabetes Mellitus.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 9, 1958, to August 22, 1958, that I last saw the deceased alive on August 21, 1958, and that death occurred at 6:15A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ellis S. Margolin M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 8/22/58
PHYSICIAN'S NAME (Type): Ellis Margolin, M.D. Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 24, 1958
22c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery
22d. LOCATION (City, town, or county) (State): Bladensburg, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons
ADDRESS: Hyattsville, Maryland
24a. REC'D BY REGISTRAR DATE: AUG 25 '58
24b. REGISTRAR'S SIGNATURE: Corinne S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After [illegible] certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film C232 8/25/58 eej

8927

CERTIFICATE OF DEATH

Reg. Dist. No. 08971

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RD 4

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE MD
b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) × WESTMINSTER
d. STREET ADDRESS RD 4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First SUSIE Middle REESE Last WOLF
4. DATE OF DEATH Month Aug Day 6 Year 19 58

5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH SEPT. 11, 1877
9. AGE (In years last birthday) 80 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME FRANCIS W. REESE
14. MOTHER'S MAIDEN NAME LIZA J. COPPERSMITH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Address R D 4 MRS OTTO SEIPP WESTMINSTER MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of rectum — INTERVAL BETWEEN ONSET AND DEATH Months
154X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
A. S. C. V. disease with hypertension
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1958, to Aug 6, 1958, that I last saw the deceased alive on Aug 5, 1958, and that death occurred at 6 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE James T. Marsh M.D. ADDRESS (Street, city or town, state) 105 E MAIN ST DATE SIGNED 8-6-58
PHYSICIAN'S NAME (Type) JAMES T. MARSH WESTMINSTER MD

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF AUG 9, 1958
22c. NAME OF CEMETERY, OR CREMATORY TRINITY LUTHERAN CEM.
22d. LOCATION (City, town, or county) SMALLWOOD (State) MD.

23. FUNERAL DIRECTOR'S SIGNATURE David C. Bankard ADDRESS Westminster, Md.
24a. REC'D BY REGISTRAR DATE AUG 11 '58
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55